CHRC Grantee Monitoring Report

Grantee Name:	**Community Health Resource**
Grantee Contact Information:	Program director; 410.555.1234; director@CHRC.gov
Grantee #:	15-001
Grant Period:	April 1, 2015 - March 31, 2017
Total Award:	$150,000
Year One Grant Award:	$75,000
Amount Paid to Date:	$0
Focus Area:	Primary Care Access
Date of this Report:	11/30/15
Additional Funds Leveraged to Date*:	

Grantee Payout and Report Schedule

Report Period	Due Date	Potential Fund Distribution	Required Items
N/A	May 1, 2015	$30,000	Signed grant agreement and approved performance measures and updated line item budget
Report Period One ** May 1, 2015 - October 31, 2015	November 30, 2015	$35,000	**Report 1**: narrative, M&D report, expenditures report and invoice
Report Period Two November 1, 2015 - April 30, 2016	May 31, 2016	$35,000	**Report 2**: narrative, M&D report, expenditures report and invoice
Report Period Three (Yr. 2) May 1, 2016 - October 31, 2016	November 30, 2016	$30,000	**Report 3**: narrative, M&D report, expenditures report and invoice
Report Period Four (Yr. 2) November 1, 2016 - April 30, 2017	May 31, 2017	$20,000	**Report 4 (Final)**: narrative, M&D report, expenditures report and invoice
	Total:	$150,000	

*List amount of additional funding leveraged from CHRC grant. Please also list the donor and the time period of the grant. (e.g., $50,000 - Weinberg Foundation (3 yr.))

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Grantee:	Community Health Resource
Grant #:	15-001
Reporting Period:	Report #1: May 1, 2015 - October 31, 2015
Project Goal(s):	Provide a medical home for uninsured/underinsured patients, reduce health disparities, and reduce preventable admissions, readmissions, and ED visits.

SHIP Focus Area(s) & Measure(s):
Access to Health Care - Persons with a usual primary care provider; Uninsured ED visits
Quality Preventative Care - ED visits due to diabetes; ED visits due to Hypertension

NOTE #1: Any measurement counting "Unduplicated" patients **CANNOT** include the same patients over different reporting periods. The "Totals" column for these measures should sum only unique individuals. For example, if an individual is counted in reporting period 1, then that person should **not** be counted again in reporting period 2.

NOTE #2: The program data with its associated data source reported by the grantee on this M&D report is subject to audit by the CHRC.

NOTE #3: The CHRC will utilize output **1c** for its "**Total patients/clients seen**" measure, and output **1d** for its "**Total patient/client encounters**" measure.

NOTE #4: "Patient/client Encounters" is defined as any face-to-face visit to a clinician in a clinical setting or a face-to-face meeting with a care manager in a care coordination program.

Process Metrics

Key Project Objectives	Output	Data Source	Year One			
			Reporting Period #1	Reporting Period #2	Totals	Goal
Provide a medical home to 3,000 uninsured/newly insured patients	1a) Total # of patients referred from ED to partner location Grantee has confirmed that patients will be screened for PCP. Patients without access to PCP, high-utilizers, and other patients will be referred to partner. A specific focus on patients without PCP or 'high utilizers' will be prioritized for referral to partner.	Navigator service logs and Athena EMR			0	3000
	1b) # of high utilizer patients screened at community health resource and referred to partner (subset of 1a). Definition of "high utilizer" is any patient visiting the ED 3 or more times in 12 months. *	Navigator service logs and Athena EMR				
	1c) # of patients referred from community health resource who received care at partner location.	Navigator service logs and Athena EMR			0	
	1d) # of primary care encounters by patients referred from community health resource to partner location.	Navigator service logs and scheduling directory of partner Athena EMR			0	
	1e) # of referred uninsured patients who are enrolled in health insurance (this is a subset of 1a)	Navigator service logs and Athena EMR			0	

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Reporting Period:	Report #1: May 1, 2015 - October 31, 2015

SHIP Focus Area(s) & Measure(s):
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Quality Preventative Care - ED visits due to diabetes; ED visits due to Hypertension

Health Metrics

Key Project Objectives	Output	Data Source	Year One			
			Reporting Period #1	Reporting Period #2	Totals	Goal
Reduce health disparities associated with diabetes and cardiovascular disease	2a) % of adult patients 18 years and older w diagnsosed hypertension whose most recent blood pressure was less than or equal to140/90. Goal is 60%	Athena EMR				60%
	2b) % of adult patients 18 years and older w Type 1 or 2 diabetes whose most recent HgBA1C is less than 8%. Goal is 60%	Athena EMR				60%

Hospital Metrics

Key Project Objectives	Output	Data Source	Year One			
			Reporting Period #1	Reporting Period #2	Totals	Goal
Reduce unnecessary ED visits, hospital admissions and readmissions.	3a) # of uninsured patients making three or more visits to the ED at community health resource	Financial Data and Cerner inpatient EMR			0	5% decrease
	3b) # of admissions for uninsured patients at community health resource	Financial Data and Cerner inpatient EMR			0	5% decrease
	3c) 30-day readmission rate of uninsured patients at community health resource	Financial Data and Cerner inpatient EMR				5% decrease
	3d) 30-day readmission rate for patients with Diabetes	Financial Data and Cerner inpatient EMR				
	3e) 30-day readmission rate for patients with Hypertension	Financial Data and Cerner inpatient EMR				

*Definition of "high utilizer" is any patient visiting the ED 3 or more times in 12 months.